Coding 'covering' physicians during the global period

Q Please explain what "by the same physician" means in the CPT definition of modifiers -24, -58, -76, and -79. Does it mean literally the same physician or can it mean within the same group practice and specialty, i.e., same tax ID number?

A Simply put, it means "the physician who performed the last procedure that initiated the global period." What makes the situation more complex is how insurance companies process claims for physicians within a group practice and how they treat covering physicians during the global period. The question then becomes: How will my insurance company view the use of these modifiers for payment purposes? For instance, the modifier -24 means that the physician who performed the original surgical procedure is now seeing the patient for an unrelated problem (E/M service) during the global period. If all physicians in a single-specialty practice are considered the "same physician" for billing purposes, use this modifier to bypass the global period restrictions for postoperative care.

The same logic might apply to the other modifiers. For example, the modifier -58 means that the surgeon who performed the first surgical procedure is now doing a staged or related procedure during the global period of the first procedure; the modifier -76 signals that the surgeon who performed the first surgical procedure is repeating that procedure for a second time; and the modifier -79 indicates that the original surgeon is performing an unrelated procedure or service during the global period.

These modifiers also apply to "covering" physicians because, in most cases, this doctor is considered the same as the patient's regular physician for billing purposes. The bottom line: The covering physician can bill for the same services and procedures as the regular clinician during the global period. The modifiers simply define the circumstances.

Outpatient obstetric care in a hospital setting

Q A gravida presented to the labor and delivery (L&D) unit of the hospital with symptoms indicative of preterm labor. A physician examined the patient and counseled her without admitting her. Is this considered an "office visit" under the global obstetric code and, therefore, counted toward the 13 antepartum visits, or is it considered a separate E/M visit that should be billed on the date of service?

A Since the physician performed an outpatient service (because the gravida was not admitted to the hospital or for observation care), most payers may consider the visit as a part of the global care, even though the service was performed in the hospital, not in an office.

Nonetheless, bill this encounter as a separate E/M visit on the date of service. The reasons: Your claim will clearly show that the place of service was not the office, and the diagnosis code will be the patient's presenting symptoms. This may help you obtain reimbursement outside of the global fee. ■

This article was written by Melanie Witt, RN, CPC, MA, former program manager in the Department of Coding and Nomenclature at ACOG. She is now an independent coding and documentation consultant. Her comments reflect the most commonly accepted interpretations of CPT-4 and ICD-9CM coding. When in doubt on a coding or billing matter, check with your individual payer.